Kalydeco (ivacaftor), Orkambi (lumacaftor-ivacaftor), Symdeko (tezacaftor-ivacaftor)

Member Information (required)	**Provider Information** (required)	
Member Name:	Provider Name:	Specialty:
ID#:	NPI#:	Contact Person
Date of Birth:	Office Phone:	Office Fax:
Pharmacy Information		
Pharmacy Name:	Pharmacy NPI:	
Pharmacy Phone:	Pharmacy Fax:	
Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
Directions for use:		

All information to be legible, complete and correct or form will be returned. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval:

1. Is the prescriber a pulmonologist or has the prescriber consulted with a pulmonologist?
   ☐Yes ☐No
2. Is the patient managed by a cystic fibrosis clinic? ☐Yes Clinic Name: _____ ☐No
3. Is the patient adherent to evidence-based inhaled and oral therapies for pulmonary cystic fibrosis?
   ☐Yes ☐No
4. Patient age: _____
5. For Orkambi or Symdeko: cystic fibrosis with laboratory-confirmed homozygous F508del mutation of the CFTR gene? ☐Yes (include a copy of the FDA-cleared CF mutation test) ☐No
6. For Kalydeco or Symdeko: which mutation in the CFTR gene? _____ (include a copy of the FDA-cleared CF mutation test)
7. Warnings and precautions:
   - Co-administration with CYP3A inducers is not recommended.
   - Transaminases (ALT and AST) should be assessed prior to initiating treatment, every 3 months during the first year of treatment, and annually thereafter.
   - Cataracts: Baseline and follow-up examinations are recommended in pediatric patients initiating treatment.

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating improved FEV1 from baseline

Authorization: 6 months
Re-authorization: 1 year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date